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Social Entrepreneurship in Religious Congregations' Efforts to Address Health Needs

Laura Werber, Ph.D.,

RAND Corporation 1776 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138 Telephone: 310-393-0411, x6897 Fax: 310-260-8160 lauraw@rand.org

Peter J. Mendel, Ph.D., and

RAND Corporation 1776 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138 Telephone: 310-393-0411, x7194 Fax: 310-260-8157 mendel@rand.org

Kathryn Pitkin Derose, Ph.D., M.P.H.

RAND Corporation 1776 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138 Telephone: 310-393-0411, x6302 Fax: 310-260-8157 derose@rand.org

Abstract

Purpose—Examine how religious congregations engage in social entrepreneurship as they strive to meet health-related needs in their communities.

Design—Multiple case studies.

Setting—Los Angeles County, California.

Participants—Purposive sample of 14 congregations representing diverse races-ethnicities (African American, Latino, and white) and faith traditions (Jewish and various Christian).

Method—Congregations were recruited based on screening data and consultation of a community advisory board. In each congregation, researchers conducted interviews with clergy and lay leaders (n=57); administered a congregational questionnaire; observed health activities, worship services, and neighborhood context; and reviewed archival information. Interviews were analyzed using a qualitative, code-based approach.

Results—Congregations' health-related activities tended to be episodic, small in scale, and local in scope. Trust and social capital played important roles in congregations' health initiatives, providing a safe, confidential environment and leveraging resources from – and for – faith-based and secular organizations in their community networks. Congregations also served as “incubators” for members to engage in social entrepreneurship.

Conclusion—Although the small scale of congregations' health initiatives suggest they may not have the capacity to provide the main infrastructure for service provision, congregations can complement the efforts of health and social providers with their unique strengths. Specifically, congregations are distinctive in their ability to identify unmet local needs, and congregations' position in their communities permit them to network in productive ways.

Keywords

Religious Congregations; Health Promotion; Collaboration; Community Networks; Social Entrepreneurship

PURPOSE

Amid political changes and economic challenges to government support for health and social services in the United States, policymakers have attempted to stimulate both entrepreneurial approaches within the nonprofit and voluntary sector and faith-based organizations' (FBOs) involvement in addressing community health and social needs.^{1, 2} For example, legislation such as the Charitable Choice provisions of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act and the 2001 establishment of the White House Office of Faith-based and Community Initiatives aimed to increase federal funding of FBOs, including congregations, to facilitate and even broaden their roles in social service delivery. President George W. Bush envisioned that FBO involvement would encourage individuals "lending their talents as 'social entrepreneurs.'"³ More recently, others have suggested that FBOs could play important roles implementing provisions of the Patient Protection and Affordable Care Act of 2010, given the limits of workplace interventions (e.g., for those unemployed or working for small employers) and the greater experience and reach of faith-based organizations in addressing health disparities among vulnerable populations.⁴

Indeed, evidence suggests religious congregations play an important role in health and social service delivery in the United States, although how these services start and are sustained is understudied. For example, 58 percent of congregations surveyed in the 1998 National Congregations Study reported engaging in social service activities⁵ pertaining to a variety of community concerns (e.g., food, housing/shelter, homelessness, health). Analyses of the same data found that 10 to 11 percent of congregations engage in formal health-related programming, usually in collaboration with secular health agencies.^{6,7} However, little is known about the organizational aspects of congregations' health-related programming, and it appears that congregations may develop and execute such programs differently than their more traditional social service programs.⁷ For example, one study proposed that "the extent to which the congregation has an entrepreneurial, innovative, open organizational culture" may play a role in their development.⁷

Accordingly, one useful way to view congregation-based health activities is through the lens of social entrepreneurship theory. Although social entrepreneurship remains an evolving construct, our literature review suggests the following common hallmarks (see also Weerwardena & Mort, 2006⁸ and Zahra et al., 2009⁹ for helpful summaries):

- A social mission, alternately described as a vision¹⁰, a commitment to create and sustain social value^{11, 12} or an intent to bring about social change.¹³
- A propensity to create and exploit opportunities to realize that mission¹⁴. As Thompson¹⁵ noted in his study on social entrepreneurs, "Opportunity is at the heart of their activities."
- Resourcefulness, particularly in compensating for resource limitations and dealing with setbacks.¹⁰

Researchers have suggested other attributes, such as significant credibility^{16,15} an abundance of social capital,¹⁴ and an ability to recruit and motivate others that also may be more—or less—relevant in particular settings. In addition, Peredo and McLean¹⁷ contend that although social entrepreneurship is often assumed to be an individual effort, it is more appropriately regarded as a collective group action.

Despite religious congregations' long history serving the most needy,¹⁸ prominence as one of the largest sources of volunteers in society,¹⁹ and prevalence throughout the world, they have not typically been studied as a source of social entrepreneurship (see Leadbeater's UK

study²⁰ as a notable exception). However, during our preliminary analyses of qualitative interview data from a study of congregational health activities, it became apparent that leaders and other members of our study congregations indeed acted as social entrepreneurs, particularly in their attempts to make health services and other resources available to the local community. In this paper, we specifically analyze the form that this social entrepreneurship took in terms of the scale and scope of activities, importance of trust and social networks, and receptive context for entrepreneurial endeavors within the congregations. The resulting insights can guide both policy makers and organizations involved in health services provision in determining the most appropriate role for congregations to play in supporting community health.

DESIGN

Our data are from a larger study that sought to understand better the range of HIV activities in which religious congregations engage as well as how and why they become involved in these activities, especially given the myriad health-related issues they might, and in some cases, do address, such as cancer, diabetes, obesity, drug and alcohol abuse, homelessness, and mental health. Given the study's exploratory nature, we employed an inductive case study design that permitted in-depth examination of congregational dynamics, triangulation of multiple data sources, and comparison of health activities across various types of congregations.^{21,22}

Setting and Sample Selection

The study focused on Los Angeles County, the second largest AIDS epicenter in the United States, and specifically on three geographic areas most highly affected by HIV according to county health department surveillance data. Through community expert interviews, the study's community advisory board (CAB), and other local sources, we compiled a list of 80 congregations potentially involved in HIV in the three study areas, to which we administered a brief telephone screening questionnaire (response rate of 88 percent). Using the screening data and assistance from CAB members, we recruited a purposive sample of 14 congregations that ranged in terms of race-ethnicity, faith tradition and denomination, and congregational size.

Procedures

We employed multiple data collection methods during several visits for each congregation. The general approach is described step-by-step in the appendix, and the protocols are available by request from the lead author. Our methods included semi-structured *interviews* with clergy and lay leaders; a *congregational information form* on congregational membership, resources, and programs or ministries; *observations* of religious services, health-related activities, and the facility and neighborhood context; a review of *archival information* (e.g., congregational documents, news stories); and *meetings* with congregation members at both the start and end of our data collection for the congregation. Overall, case study data collection began December 2006 and ended for the final congregation in May 2008 (lasting an average of 7 months per congregation). A total of 57 individuals were interviewed across the 14 congregations, including clergy and lay leaders. Informed consent was obtained orally prior to the start of each interview. The interviews typically lasted 1.5 hours (range 1 to 4 hours) and were audio-recorded and transcribed.

After completing field work, we extensively coded interview transcripts to identify prominent themes using both inductive and *a priori* approaches. The interview data themselves suggested important concepts to examine, while our initial conceptual review,

questions from the interview protocol, and the research team's experience guided the selection of additional themes.²³

Six members of the study team, including the authors of this article, coded the interviews using qualitative data analysis software.²⁴ Coding pairs worked together closely throughout the process to ensure they developed and retained a shared understanding of a particular code. The coding teams drafted an initial set of major thematic categories, including types of congregational health activities, how activities are organized, the involvement of external entities, and facilitators of and barriers to these activities. Subsequent coding iterations further refined the major thematic codes.

For this paper, we went back and forth between the interview data and potentially relevant literature to heighten our understanding of the phenomenon we observed,²⁵ namely social entrepreneurship within religious congregations. For example, after coding passages about the congregations' missions and both the features and facilitators of their health activities, the entrepreneurial character of those activities, such as their embodiment of a social mission and the importance of social capital, emerged. Accordingly, we reviewed research on social entrepreneurship and then conducted additional analyses to examine further the nature of social entrepreneurship undertaken.

FINDINGS

We achieved variation in our case study sample on key congregational characteristics: predominant race/ethnicity, religious faith or denomination, and congregation size (Table 1). Overall, six congregations were predominantly (>70 percent) African American, four were Latino, two were white, and two had no predominant race or ethnic group. Of the 57 interview participants, 22 were African Americans, 18 were white, 15 were Latino, and 1 each of Asian and other (mixed race). Slightly more men (30) than women (27) were interviewed, and slightly more lay leaders (35) than clergy (22).

Through our coding, we verified that the congregations differed in the nature and extent of HIV activities, the focus of the overall study, as well as in initiatives related to other health concerns. All 14 congregations offered HIV-related activities, albeit variably, as well as health activities. Our analysis also illuminated several aspects of congregations' entrepreneurial pursuits, including the scale and scope of their activities, the trust and social networks that congregations typically develop in their community, and their ability to cultivate a haven for social entrepreneurship among their own membership. We did not find differences in social entrepreneurial tendencies for HIV initiatives versus those related to other health needs, but given the overall sampling design and study goals, we analyzed and report on HIV pursuits separately from other health-related endeavors.

Scale and scope of activities

Overall, congregations' health initiatives tended to be small in scale and local in scope. With respect to scale, during interviews we asked clergy and lay leaders to describe their congregations' health activities. Although we did not systematically inventory the number of people who attended each health-related event, interviewees' responses often included qualitative estimates of an event's capacity. These comments suggested that the number of people reached typically ranged from single or double digits for an activity like HIV testing to the low hundreds for a health fair. A notable exception is one congregation's annual community service event, which has grown over the years to include numerous volunteers and organizations across the entire region. The scope of this activity, as well as a few others such as international AIDS relief efforts, differed from most of the other entrepreneurial pursuits, which tended to focus on a neighborhood or even the immediate vicinity of a

congregation. For example, a Catholic lay leader described the scope of her church's HIV-related efforts:

Well, we do a lot of work in the South Central [Los Angeles] area. But we don't limit ourselves. We're not saying that it's only South Central, but we do a lot because that's where the majority of the congregation is and that's where we're finding statistics show that the [HIV] rate is increasing. (Lay leader, large African American and Latino Catholic church)

While the relatively low number of people served or reached may be considered a drawback, these small scale, local approaches do have their advantages. Specifically, a religious congregation's presence in the local community provides it with intimate knowledge of local social needs. As Zahra and his colleagues¹ noted in their discussion of “social bricoleurs,” which they defined as someone who uses resources at hand and improvisational skills to address local social needs, “Many social needs are non-discernable or easily misunderstood from afar, requiring local agents to detect and address them.” (This follows earlier work by Weick²⁶ who described a bricoleur more broadly as “someone who is able to create order out of whatever materials were at hand.”) This dynamic was evident in a large Latino Catholic church's partnership with a local health care provider: some of the congregants lacking health insurance or access to health care were undocumented immigrants, and the church's pastor was trusted enough to be aware of this need *and* had the means to address it by entering into a partnership that resulted in a parish nurse program and other health initiatives. In addition, across many of the congregations, we heard that congregants were reluctant to talk about HIV, largely due to taboos around sexual behavior (especially same sex relations) and the stigma related to the disease itself. Yet, we found that clergy often have knowledge of needs that others may not. Several clergy discussed how people living with HIV, or their families, would confide in them and ask for support in terms of pastoral care, hospital visitation, financial assistance, referrals to treatment, or presiding over a funeral.

Trust and social networks

The trust that many community members have towards religious congregations infuses and facilitates congregations' social entrepreneurship. This trust may not only stem from the personal attributes and reputation of individual clergy but is often regarded as inherent in the clergy role itself. The following remarks from the pastor of a large Latino Catholic church convey the trust and influence he enjoys, as well as the care he takes with the trust congregants granted him:

[W]e have tried to make use of the pulpit, especially with Hispanics; what is said there they respect and if they're asked to, they will collaborate and participate. That is to say, they confide in me, they trust that I will not deceive them, you see? Not long ago someone came and spoke with me, wanting to help Hispanics in an area that... but once I listened to him and learned about what he was doing [that he only wanted to sell them something], I said, “No, get out of here, go away.” Because I gave my word and they trust my word and he was taking advantage of it.” (Clergy leader, large Latino Catholic church)

As these comments illustrate, such faith in a particular leader or the clergy role more generally can translate into a willingness to take chances in new endeavors:

It's like our pastor has a vision, and once she has that vision, she put it out to the congregation, and we just go with that vision, if that's what God is leading us, because we truly believe that she is a woman who is led by God, and in a lot of... different areas of the whole person. (Lay leader, small mixed race-ethnicity non-denominational church)

Likewise, the trust that a congregation enjoys is derived from the reputation and credibility it has earned over time as well as its status as an institution regarded as a safe haven. The lay leader responsible for a Latino and Anglo Catholic church's parish nurse program told us:

I think most of the Hispanics come and I think they really trust us and they also know that if they're not documented, that currently you cannot force a church to give up its records. So ... whatever my political stand is, they can come and see me and they know that ... they can come anonymously, and that the church ... it's not forced to give away their records... (Lay leader, large Latino and Anglo Catholic church)

In some instances, this trust in the congregation extended beyond its membership to the community. Several of our congregations were regarded as credible, legitimate organizations committed to serving local HIV or other health-related needs. For example, one synagogue's HIV support group included participants who were not congregation members. Moreover, some were not even Jewish, but felt they were in an established, supportive setting and trusted that their HIV-positive status would be kept confidential.

In another example, an African American church's earlier efforts to trim trees and address other community concerns laid the foundation for trust with local Latino immigrant residents and their participation in the church's health fair:

[I]t brought a relationship, so when we came back with the flyers, and we started receiving the grants, it became easy for us to trust and depend on those various people in the community to come... Hispanic people came ... and they talked to their friends, and they have their families come in, and it really brought a really good relationship. But for the most part, with the health issues, with the health fair ... I think, every person in the neighborhood came to one in particular, and we were giving out free clothes, but everybody stopped at a booth... they just came, they came because even in not speaking English, the Hispanics felt comfortable because they knew our faces and they knew that we had done things before. (Lay leader, medium-sized African American Baptist church)

As noted earlier, some social entrepreneurship researchers have emphasized the importance of credibility, social capital, and an ability to secure the trust of others. Drayton²⁷ refers to this ability as ethical fiber, which he contends is critical for social entrepreneurship because significant social change requires “leaps of faith” and only in a trusting environment can different stakeholders have an open, honest dialogue. Waddock and Post²⁸ refer to this attribute as credibility, and note it enables the entrepreneur to obtain necessary resources and to develop a supportive network. Mair and Martí¹⁴ observe that numerous researchers have underscored the importance of networks for social entrepreneurship. Specifically, they cite the work of Burt²⁹ to explain that a well-connected network affords the social entrepreneur with access to information, resources, and support.

The case study congregations appeared to enjoy such network benefits, which included support from both faith-based and secular organizations. Most of the congregations were part of faith-based associations such as denomination-based groups (e.g., the Catholic Church's deanery for parishes in the same region) and inter-faith alliances. These associations provided an opportunity for networking that fosters social entrepreneurship. In one such example, churches within the same inter-faith council participated in a friendly weight loss competition that involved “Gospel aerobics” and healthier eating.

Our congregations' networks also included secular organizations. The following demonstrates how leveraging such network connections helped congregations fulfill their health-oriented social mission:

It was in the early nineties, when I think at the time it was the [local research institution], and they had sent a representative out to talk about breast cancer. That was the thing that they were pushing strongly then. And I became involved, and [female parishioner] was a friend. At that time she was an LVN [licensed vocational nurse], but now she's a registered nurse....and I think the incentive was that once [the church] finished the [study], they got a free computer and so that was our involvement. But it was more than the incentive of the computer. It was a heartfelt thing. [The female parishioner] was explaining to the congregation-to the women... She had a lot of meetings with just the women in private, because sometimes women don't want to talk about certain things in front of men. So she had a lot of private meetings with them, and it was very successful. (Clergy leader, large African American Pentecostal church)

Our congregations not only used these linkages to help their own members, but also to support other organizations in their network, and consequently, broader community members, as this excerpt demonstrates:

When I was training for the marathon, and I ran, unintended, ran across the person with [local HIV/AIDS support agency], he's the one that actually approached me after he found out that I was at [this congregation] and got the connection. He said, "Hey, you know, we've been talking about having a spiritual connection [for clients]. Maybe we can set up a meeting." I said, "Sure. Just call me any time. Let's do it." So, he came in. And we're going to lead a workshop... about crystal meth. So we figure that's a good way to continue to build on a relationship with them and the church let them know again that this is yet another instance of the church reaching out and showing that it cares. (Lay leader, medium-sized mixed race-ethnicity Mainline Protestant church)

Haven for social entrepreneurship

Case study congregations provided a highly receptive context³⁰ for social entrepreneurship. Specifically, clergy not only initiated entrepreneurial pursuits but also cultivated an atmosphere in which congregants were encouraged to do the same. As a rabbi told us:

[M]y job is, is to get out of the way, to identify talented people to do the right things and to give them every bit of support I can to do what they feel passionate about and to then draw in many other people along the same model of community organizing and activism. (Clergy leader, large Anglo Reform Judaism synagogue)

This practice is reminiscent of a business incubator, defined in management literature as a shared facility that provides its tenant companies with value-added monitoring and assistance.³¹ Benefits offered by business incubators include services and equipment that otherwise might be unattainable to new enterprises, such as a group of peers that provide advice, social connections, psychological support, and the visibility and legitimacy resulting from the association with a well-known incubator.³²

Interview evidence indicates that our case study congregations conferred some of these benefits to would-be social entrepreneurs within their membership. Congregations often have institutional trust and credibility, which may extend to congregants engaging in social entrepreneurship sponsored by their congregation. Congregations also offer resources that may facilitate their members' entrepreneurial initiatives. For example, a congregation's organizational structure can be empowering:

Usually things are carried out in an organized way we call ministries. We have 40 ministries here. ... So then it's up to the ministry group. Many of them meet monthly, quarterly, and they have a mission statement. Their mission statement has

to connect with the larger mission statement of the church so that we're carrying out what we say we are about. And then they initiate their own efforts. (Clergy leader, large African American and Latino Catholic church)

Other congregations resembled this church in having their health initiatives led by a relatively autonomous ministry or committee established for that purpose. We also found that like-minded individuals were attracted to some of the congregations because of their social mission. Similar to business incubators, having a group of change-oriented peers within the same institution proved auspicious for social entrepreneurship, as illustrated by this quotation about a synagogue's possible activities in response to the link between crystal methamphetamine abuse, risky sexual behavior, and HIV:

It's an AA [Alcoholics Anonymous] HIV support group... I remember the days when there were a dozen very bleak people in a room. Now we get 110-120 people, and it's primarily because of crystal meth. [With] the sexual behavior that goes on with that [crystal methamphetamine use], the two kind of dovetail. I would like to bring that more to the forefront in the temple. We have another temple member who is one of the foremost researchers on crystal meth use in the gay male community... And I've told her, I said, I want you to put your thinking cap on ... if we can expand something to do with the sober community and the drug community...[we can make a difference] (Lay leader, medium-sized Anglo Reform Judaism synagogue)

Such connections between similarly-motivated members, along with congregational resources like organizational structure, funding, physical space, and institutional-level credibility, created a uniquely supportive context for case study congregations to address health-related needs in the local community.

CONCLUSION

Our study focused on religious congregations' efforts to address the HIV and other health-related needs in communities highly affected by the HIV epidemic. During our case study research, specifically as we examined congregations' interactions with other organizations, we found evidence of social entrepreneurship and accordingly sought to understand better such pursuits. This study relied on a purposive sample and thus is not representative of congregations across the United States, but its in-depth examination of a range of congregations provides insight into the nature of social entrepreneurship in congregational settings. In doing so, it suggests implications for policy and practice related to congregations' involvement in health and social services delivery.

Similar to other research on religious congregations,³³ our congregations' initiatives usually were small in scale and local in scope. This is also consistent with the "social bricoleur" category in Zahra and colleagues' typology of social entrepreneurs.¹ A second distinct feature of social entrepreneurship in congregational settings was the value of social capital. Borrowing a term from Coleman,³⁴ congregations' social capital was "appropriable;" it was accrued by and for purposes other than health promotion yet was available for that use. Their network connections helped congregations obtain support for their members' and broader community members' health needs, and the level of trust congregations enjoyed also aided the fulfillment of their social mission. Another compelling aspect of religious congregations as social entrepreneurs was their role as "incubators" in cultivating social entrepreneurship, and, by extension, support for the local community.

Our study results contribute to the growing body of research on religious congregations' roles in addressing their communities' health and social needs. Congregations of diverse faiths can be found in virtually any community around the world—and their efforts to meet

more than their communities' spiritual needs are common internationally.^{20,35} Moreover, while many nonprofits and volunteer organizations are relatively young, arising in response to new social needs, and possibly even fleeting, given funding challenges and other impediments, many religious congregations are decades or even centuries old. The spiritual and service-oriented missions of such congregations, coupled with their deep entrenchment as social institutions, provide them with a staying power that spans the ebb and flow of different social needs. One might even count religious congregations among the earliest social entrepreneurs, given their long-standing community presence, unique awareness of local needs, and innovativeness in the face of ongoing resource constraints.

The prevalence and enduring nature of religious congregations suggest that our study, and additional research in this area, have practical implications. The potential role of religious congregations in promoting health and reducing health disparities has become of increasing interest to public health professionals and policymakers over the last three decades.³⁶⁻⁴⁰ Current trends, including the devolution of government programs towards the private and nonprofit sectors, and the increased reliance on inter-sectoral collaborations—networks, alliances, or partnerships among public, secular, and faith-based nonprofits and for-profit organizations⁴¹—have only further increased calls to incorporate and enlist faith-based organizations such as religious congregations into addressing public health issues in local communities. Yet despite a growing literature on congregation-based health programs,⁴²⁻⁴⁴ organizational aspects of congregational involvement in health have been largely ignored.⁷ Further, much of the literature on congregation-based health activities has focused on interventions developed as part of a research project⁴⁵⁻⁴⁷ and not on congregational health activities more generally.

Although we lack data on the impact of the health-related programs conducted by our congregations, our findings on congregations' social entrepreneurship to address health suggest some strengths and limitations of congregational health efforts. For example, there may be instances in which the small-scale, locally-focused efforts of entrepreneurial congregations are ideal and other cases where they are less appropriate. However, if religious congregations tend to engage in the "social bricoleur" form of social entrepreneurship, they may be better suited as *collaborators* with external health and social service providers rather than the primary infrastructure for ongoing service provision. It is therefore unlikely that congregational health efforts will be able to compensate fully for cuts to government spending on health and social service programs. Instead, external health and social service providers could benefit from congregations' distinct abilities to identify unmet local needs and, given their position of trust and credibility, to network effectively within their local community.

Understanding congregations' entrepreneurial capacities is important to inform the practice of faith-based health promotion. Efforts to identify the optimal conditions for religious congregations' social entrepreneurship could help service providers and policymakers develop collaborative efforts that more effectively build on congregations' strengths.

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Appendix: Congregation Case Study Data Collection Steps

1. An initial *recruitment meeting* was held where we documented background information about the congregation.

2. A congregation representative completed *congregational information form* to provide information about congregation demographics, resources, and health services and programs.
3. *Interviews* were conducted with at least one member of the clergy and one lay leader knowledgeable of the congregation's health services and programs. Typically three to six interviews were completed, and topics included the following:
 - a. Leader's background and experience
 - b. Background and personal characteristics
 - c. Congregational mission
 - d. Congregational priorities
 - e. Congregational polity
 - f. Congregational history of involvement in health issues
 - g. Congregational history of involvement in HIV/AIDS issues
 - h. Denominational and congregational policies regarding HIV/AIDS
 - i. Leader and congregational attitudes
 - j. Community attitudes
 - k. Community dynamics
4. *One field observation* was conducted and documented. The purpose of the field observation was to provide descriptions of the physical infrastructure and activities of people in and around the congregation space that specifically give insight into:
 - a. Resources of the congregation (physical assets, general affluence)
 - b. Activities of the congregation (e.g., what functions different space may be dedicated to, how people use the space/facilities)
 - c. Social structure and climate within the congregation (e.g., status-consciousness/hierarchy, differentiation of administrative and other functions; tone or atmosphere of the space that reflects character of congregation)
 - d. Relationship to the surrounding community (e.g., visibility, openness)
5. *One religious service observation* (or multiple observations for multiple weekend services) was conducted and documented. The purpose of the religious service observation was to provide additional, first-hand information about the congregation in terms of:
 - a. Size and demographics (number of attendees, demographic breakdown in terms of race-ethnicity, languages, gender, and age).
 - b. Leadership structure (clergy vs. lay role)
 - c. Theological orientation and worship style (focus on spiritual vs. social issues, conservative vs. liberal interpretations of scripture, tone and level of congregation participation)
 - d. Issues and activities that seem to be salient to the congregation (level of involvement in community and health issues, upcoming important events, handouts or other materials distributed)

6. *One health program observation* was conducted and documented to obtain an overall “feel” for the event. Aspects of the health program or activity that were recorded include the following:
 - a. Who organized the event
 - b. Demographics of the attendees (e.g., rough estimate of gender, age, and racial/ethnic composition)
 - c. Description of the event, to include the program or agenda, the nature of the venue, the atmosphere, and any activities that preceded or followed the actual event.
7. *Archival information*, such as media accounts of congregational activities, minutes from health committee or ministry meetings, and congregational newsletters, was obtained from the congregation directly or through database searches and reviewed for additional context.
8. *A congregational feedback session* was conducted where we presented a summary of the congregations’ “story” around health activities (e.g., how they started, who has been involved, what they've done, how they've evolved and/or been sustained over time, factors that influenced the development and sustaining of programs) to congregational clergy and lay leaders for validation and discussion. We took systematic notes at these feedback sessions for correction and augmentation of congregational information.

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SO WHAT? Implications for Health Promotion Practitioners and Researchers

What is already known on this topic?

Religious congregations reach a large proportion of the U.S. population and can be leveraged for health promotion. Much of the literature has focused on health interventions initiated by researchers. Less is known about congregational health activities more generally and exactly how these activities come about.

What does this article add?

This article explores congregational perspectives about what facilitated their health activities and identifies aspects of these efforts that reflect social entrepreneurship, particularly in terms of starting health initiatives.

What are the implications for promotion practice or research?

This information should help health and social service providers and others interested in leveraging congregations' health promotion potential to understand better the types of collaborative efforts that would build on congregations' strengths.

Table 1**Congregation and Interview Participant Characteristics**

Congregations (n=14)	Number
Predominant race/ethnicity ¹	
African American	6
Latino	4
White	2
Mixed	2
Congregation size ²	
Large (501 members)	6
Medium (151-500 members)	5
Small (150 members)	3
Denomination	
Catholic	3
Evangelical/Pentecostal/Non-denominational	4
Mainline Protestant	4
Jewish (Reform)	2
Baptist	1
Interview Participants (n=57)	Number
Race/ethnicity	
African American	22
Latino	15
White	18
Asian	1
Other	1
Gender	
Female	27
Male	30
Role	
Clergy	22
Lay	35

¹ Requires race/ethnicity to comprise 70% of regular participants.

² Measured in terms of regularly attending congregational participants.